2015

SUMMARY OF BENEFITS

Kansas State Employee Health Plan (KSEHP)

Advantra Freedom (PPO)

Offered by
Coventry Health and Life Insurance Company

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

YOU HAVE CHOICES ABOUT HOW TO GET YOUR MEDICARE BENEFITS

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **Advantra Freedom (PPO))**.
- You may have other options too, such as a Medicare group plan offered through your employer group, union or trust.

TIPS FOR COMPARING YOUR MEDICARE CHOICES

This Summary of Benefits booklet gives you a summary of what **Advantra Freedom (PPO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on http://www.medicare.gov.

- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTIONS IN THIS BOOKLET

- Things to Know About **Advantra Freedom (PPO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Prescription Drug Benefits
- Covered Medical and Hospital Benefits

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-(800)-727-9712.

Things to Know About **Advantra Freedom (PPO)**

Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time.
- From February 15 to September 30, you can call us Monday from 8:00 a.m. to 8:00 p.m. Central time, Tuesday from 8:00 a.m. to 8:00 p.m. Central time, Wednesday from 8:00 a.m. to 8:00 p.m. Central time, Thursday from 8:00 a.m. to 8:00 p.m. Central time, Friday from 8:00 a.m. to 8:00 p.m. Central time, Saturday from 8:00 a.m. to 8:00 p.m. Central time.

Advantra Freedom (PPO) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-(800)-727-9712
- If you are not a member of this plan, call toll-free 1-(800)-727-9712
- Our website: http://www.coventry-medicare.coventryhealthcare.com

WHO CAN JOIN?

To join **Advantra Freedom (PPO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and be eligible through your employer group, union or trust.

Our service area includes the following counties in:
Arkansas: Benton, Carroll, Crawford, Franklin, Logan, Madison, Montgomery, Pulaski, Scott, Sebastian, Washington, White.

Kansas: Allen, Anderson, Atchison, Bourbon, Butler, Cherokee, Douglas, Franklin, Geary, Harvey, Jackson, Jefferson, Johnson, Labette, Leavenworth, Linn, Miami, Montgomery, Osage, Pottawatomie, Riley, Sedgwick, Shawnee, Wabaunsee.

Missouri: Barry, Barton, Bates, Benton, Caldwell, Carroll, Cass, Cedar, Christian, Clay, Clinton, Dade, Dallas, Douglas, Greene, Henry, Hickory, Jackson, Jasper, Johnson, Laclede, Lafayette, Lawrence, Livingston, McDonald, Newton, Ozark, Pettis, Phelps, Platte, Polk, Pulaski, Ray, Saline, Stone, St. Clair, Taney, Vernon, Webster, Wright.

Oklahoma: Canadian, Cleveland, Grady, Lincoln, Logan, Muskogee, Oklahoma, Pottawatomie, Tulsa

WHICH DOCTORS, HOSPITALS, AND PHARMACIES CAN I USE?

Advantra Freedom (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

You must generally use network pharmacies to fill your prescriptions for covered Part D

drugs.

Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies. You can see our plan's provider and pharmacy directory at our website (http://www.providerdirectory.coventry-medicare.com).

Or, call us and we will send you a copy of the provider and pharmacy directories.

WHAT DO WE COVER?

Like all Medicare health plans, we cover everything that Original Medicare covers - and *more*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website http://KSformulary.coventry-medicare.com.

Or, call us and we will send you a copy of the formulary.

HOW WILL I DETERMINE MY DRUG COST?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact COVENTRY HEALTH CARE for details.

SECTION II - SUMMARY OF BENEFITS	
KSEHP Advantra Freedom (PPO)	
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES	
How much is the monthly premium?	**$188** per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: $1,000 for services you receive from in-network providers. $10,000 for services you receive from out-of-network providers. $10,000 for services you receive from any provider. Your limit for services received from in-network providers and your limit for services received from out-of-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	No. There are no limits on how much our plan will pay.
COVERED MEDICAL AND HOSPITAL BENEFITS	
NOTE: **SERVICES WITH A [1] MAY REQUIRE PRIOR AUTHORIZATION.** **SERVICES WITH A [2] MAY REQUIRE A REFERRAL FROM YOUR DOCTOR.**	

OUTPATIENT CARE AND SERVICES	
Acupuncture and Other Alternative Therapies	Not covered
Ambulance[1]	In-network and Out-of-network: $100 copay Non-emergent transportation requires prior authorization. Cost sharing is listed for a one-way trip.
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): In-network: $20 copay Out-of-network: 20% of the total cost
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): In-network: $0-150 copay, depending on the service • Medicare covered dental office services: You pay nothing • Medicare covered dental services at an outpatient hospital facility or ambulatory surgical facility: $150 copay Out-of-network: 20% of the total cost If a doctor provides services in addition to your exam, separate physician or facility cost sharing may apply.
Diabetes Supplies and Services[1]	Diabetes monitoring supplies: In-network: $0-5 copay or 20% of the total cost, depending on the supply; • Glucose monitors from our preferred vendor One Touch/Lifescan: You pay nothing • Diabetic test strips and lancets from our preferred vendor One Touch/Lifescan: You pay nothing • Glucose monitor from non-preferred vendors (non-OneTouch/Lifescan): 20% of the total cost • Diabetic test strips and lancets from our non-preferred vendors (non-OneTouch/Lifescan): $5 copay

	Out-of network: 20% of the total cost Diabetes self-management training: In-network: You pay nothing Out-of-network: 20% of the total cost Therapeutic shoes or inserts: In-network: 20% of the total cost Out-of-network: 20% of the total cost If a doctor provides services in addition Diabetes self-management training, separate physician or facility cost sharing may apply. (*See Doctor's office visits)* Diabetic supplies and services are limited to specific products and/or brands. Prior authorization is required for non-Lifescan monitors and testing supplies, test strips (any brand) in excess of 100 strips every 30 days, and monitors (any brand) in excess of one monitor per year.
Diagnostic Tests, Lab and Radiology Services, and X-Rays[1]	Diagnostic radiology services (such as MRIs, CT scans): In-network: You pay nothing Out-of-network: 20% of the total cost Diagnostic tests and procedures: In-network: You pay nothing Out-of-network: 20% of the total cost Lab services: In-network: You pay nothing Out-of-network: 20% of the total cost Outpatient x-rays: In-network: You pay nothing Out-of-network: 20% of the total cost Therapeutic radiology services (such as radiation treatment for cancer): In-network: You pay nothing Out-of-network: 20% of the total cost If a doctor provides services in addition to diagnostic tests and therapeutic services, separate physician or facility cost share may apply. *(See Doctor's office visit or Outpatient Surgery/Outpatient hospital)*
Doctor's Office Visits	Primary care physician visit: In-network: $10 copay

	Out-of-network: 20% of the total cost Specialist visit: In-network: $25 copay Out-of-network: 20% of the total cost A separate cost share may apply to certain diagnostic tests. *(See Diagnostic Tests, Lab and Radiology Services, and X-ray)*
Durable Medical Equipment *(Wheelchairs, oxygen, etc.)*[1]	In-network: 20% of the total cost Out-of-network: 20% of the total cost
Emergency Care	In-network and Out-of-network: $50 copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the total cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. We provide worldwide coverage for emergency care.
Foot Care *(podiatry services)*	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: In-network: $30 copay for Medicare-covered podiatry visits And $15 copay for up to 2 supplemental routine podiatry visits every year. Out-of-network: 20% of the total cost for Medicare-covered podiatry visits.
Hearing Services	Exam to diagnose and treat hearing and balance issues: In-network: You pay nothing for Medicare-covered hearing visits and you pay nothing for up to 1 routine hearing test every year. You are covered up to $500 for hearing aids every three years. Out-of-network: 20% of the total cost for Medicare-covered hearing visits.
Home Health Care[1]	You pay nothing If home health services do not require authorization. If home health agency provides services in addition to skilled nursing or therapy, separate cost sharing or authorization requirement may apply.

Mental Health Care[1]	Inpatient visit: Our plan covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital. Our plan covers 90 days for an inpatient hospital stay. Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days. In-network: $150 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing for lifetime reserve days Out-of-network: 20% of the total cost per stay Your inpatient benefits will begin on day one each time you are admitted within or to a specific facility type. A transfer within or to a facility, including Inpatient Rehabilitation, Long Term Acute Care, Inpatient Acute or Psychiatric facility is considered a new admission. Outpatient group therapy visit: In-network: $15 copay Out-of-network: 20% of the total cost Outpatient individual therapy visit: In-network: $30 copay Out-of-network: 20% of the total cost Partial hospitalization: In-network: You pay nothing Out-of-network: 20% of the total cost
Outpatient Rehabilitation[1]	Pulmonary and Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): In-network: You pay nothing Out-of-network: 20% of the total cost Occupational therapy visit: In-network: You pay nothing

	Out-of-network: 20% of the total cost Physical therapy and speech and language therapy visit: In-network: You pay nothing Out-of-network: 20% of the total cost
Outpatient Substance Abuse[1]	Outpatient group therapy visit: In-network: $15 copay Out-of-network: 20% of the total cost Outpatient individual therapy visit: In-network: $30 copay Out-of-network: 20% of the total cost
Outpatient Surgery[1]	Ambulatory surgical center: In-network $150 copay Out-of-network: 20% of the total cost Outpatient hospital: In-network: $150 copay Out-of-network: 20% of the total cost A separate cost share may apply to certain diagnostic tests. (*See Diagnostic Tests, Lab and Radiology Services, and X-ray)*
Over-the-Counter Items	Not Covered
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices In-network: 20% of the total cost Out-of-network: 20% of the total cost Related medical supplies: In-network: 20% of the total cost Out-of-network: 20% of the total cost
Renal Dialysis[1]	In-network: You pay nothing Out-of-network: 20% of the total cost
Transportation	Not covered
Urgent Care	In and out-of-Network: $30 copay
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): In-network: • Medicare-covered exams to diagnose and treat disease and conditions of the eye: You pay nothing • Glaucoma screening: You pay nothing

	• Routine eye exam (for up to 1 every year): You pay nothing Out-of-network: 20% of the total cost for Medicare-covered exams and for supplemental routine eye exam. Eyeglasses or contact lenses after cataract surgery: In-network: You pay nothing Out-of-network: 20% of the total cost If a doctor provides services in addition to your exam, separate physician or facility cost sharing may apply.
Preventive Care	In-network: You pay nothing Out-of-network: 20% of the total cost Our plan covers many preventive services, including: Abdominal aortic aneurysm screening Alcohol misuse counseling Bone mass measurement Breast cancer screening (mammogram) Cardiovascular disease (behavioral therapy) Cardiovascular screenings Cervical and vaginal cancer screening Colonoscopy Colorectal cancer screenings Depression screening Diabetes screenings Fecal occult blood test Flexible sigmoidoscopy HIV screening Medical nutrition therapy services Obesity screening and counseling Prostate cancer screenings (PSA) Sexually transmitted infections screening and counseling Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots "Welcome to Medicare" preventive visit (one-time) Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered. Wellness education and supplemental benefits and

	services include: • Health Education with semi-annual newsletters • Nutritional Benefits which are available by a licensed nutritionist or other healthcare provider as part of Disease Management. • Nursing Hotline to call a nurse for assistance with Medical questions 24-hours a day, 7-days a week. • Membership in Health Club/Fitness Classes through a network of participating fitness facilities. Goal is to promote fitness, exercise and better health choices and improve the overall health of participating members. Members will receive an orientation to the gym facility and its equipment. In-network: You pay nothing Out-of-network: $50 copay for supplemental education and wellness programs.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the total cost for drugs and respite care.
INPATIENT CARE	
Inpatient Hospital Care[1]	Our plan covers an unlimited number of days for an inpatient hospital stay. In-network: $150 copay per day for days 1 through 5 You pay nothing per day for days 6 through 90 You pay nothing per day for additional non-Medicare covered hospital days Out-of-network: 20% of the total cost Your inpatient benefits will begin on day one each time you are admitted within or to a specific facility type. A transfer within or to a facility, including Inpatient Rehabilitation, Long Term Acute Care, Inpatient Acute or Psychiatric facility is considered a new admission.
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)[1]	Our plan covers up to 100 days in a SNF. In-network: You pay nothing per day for days 1 through 20 and $156.50 copay per day for days 21 through 100 Out-of-Network: 20% of the total cost

PRESCRIPTION DRUG BENEFITS

How much do I pay?

For Part B drugs such as chemotherapy drugs[1]:

In-network: 20% of the total cost
Out-of-network: 20% of the total cost

Other Part B drugs[1]:

In-network: 20% of the total cost
Out-of-network: 20% of the total cost

Some immunizations are covered under your prescription drug plan and can be administered by your Pharmacist. Your cost share may be higher if you get these immunizations at your doctor's office.

Initial Coverage

You pay the following until your total yearly drug costs reach $2,960. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail order pharmacies.

Preferred Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0	$0	$0
Tier 2 (Non-Preferred Generic)	$5 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	$45 copay	$90 copay	$90 copay
Tier 4 (Non-Preferred Brand)	50% of the total cost	50% of the total cost	50% of the total cost
Tier 5 (Specialty Tier)	33% of the total cost	Not Offered	Not Offered

Standard Retail Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$5 copay	$10 copay	$10 copay
Tier 2 (Non-Preferred Generic)	$10 copay	$20 copay	$20 copay

Tier 3 (Preferred Brand)	$45 copay	$90 copay	$90 copay
Tier 4 (Non-Preferred Brand)	50% of the total cost	50% of the total cost	50% of the total cost
Tier 5 (Specialty Tier)	33% of the total cost	Not Offered	Not Offered

Standard Mail Order Cost-Sharing

Tier	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	$0	$0	$0
Tier 2 (Non-Preferred Generic)	$5 copay	$10 copay	$10 copay
Tier 3 (Preferred Brand)	$45 copay	$90 copay	$90 copay
Tier 4 (Non-Preferred Brand)	50% of the total cost	50% of the total cost	50% of the total cost
Tier 5 (Specialty Tier)	33% of the total cost	Not Offered	Not Offered

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy and pay the same as an in-network pharmacy, but you will get less of the drug.

Coverage Gap

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $2,960.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap.

Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

Preferred Retail Cost Sharing

Tier	Drugs Covered	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	All	$0	$0	$0

Standard Retail Cost Sharing

Tier	Drugs Covered	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	All	$5 copay	$10 copay	$10 copay

Standard Mail Order Cost Sharing

Tier	Drugs Covered	One-month supply	Two-month supply	Three-month supply
Tier 1 (Preferred Generic)	All	$0	$0	$0

Catastrophic Coverage

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of:

5% of the total cost, or $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.